DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORMAPPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING_ 445481 B. WING NAME OF PROVIDER OR SUPPLIER 01/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37560 SUMMARY STATEMENT OF DEPICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE IΛG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 157 483.10(g)(14) NOTIFY OF CHANGES F157 F 157 (INJURY/DECLINE/ROOM, ETC) SS=G What corrective action(s) will (g)(14) Notification of Changes. be accomplished for those (i) A facility must immediately inform the resident; residents found to have been consult with the resident's physician; and notify, affected by the deficient consistent with his or her authority, the resident representative(s) when there ispractice: (A) An accident involving the resident which Physician notified of weight loss results in injury and has the potential for requiring of resident #114 on January 26, physician intervention: 2017, with no new orders at (B) A significant change in the resident's physical, that time. Physician visited mental, or psychosocial status (that is, a with resident on 2/15/17. New deterioration in health, mental, or psychosocial status in either life-threatening conditions or . nutritional interventions clinical complications); ordered. (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of How you will identify other treatment due to adverse consequences, or to residents having the potential commence a new form of treatment); or to be affected by the same deficient practice and what (D) A decision to transfer or discharge the resident from the facility as specified in corrective action will be taken: §483,15(c)(1)(ii). All residents' charts reviewed (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that for weight loss that would all perlinent information specified in §483.15(c)(2) trigger physician notification is available and provided upon request to the under the facility policy for physician. significant weight loss and (iii) The facility must also promptly notify the confirmation that physician was resident and the resident representative, if any, notified. Review of weights and when there isnotifications completed on (A) A change in room or roommate assignment 2-16-17. LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE harlotte, M. Cochran 2-17-17 TITLE (XB) DATE administrator Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossible 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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02-28-17 14:51 FROM- asbury place baysmon +4232458997

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FÖRM APPROVED <u>OMB NO. 0938-03</u>91 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED. 4454R1 B WING 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAO DATE DEFICIENCY) Continued From page 1 What measures will be put in F 157 as specified in §483.10(e)(6); or to place or what systemic changes will you make to (B) A change in resident rights under Federal or State law or regulations as specified in paragraph ensure that the deficient (e)(10) of this section. practice does not recur: (iv) The facility must record and periodically update the address (mailing and email) and Policy and procedure for weight phone number of the resident representative(s). loss and physician notification This REQUIREMENT is not met as evidenced reviewed and updated on Based on medical record review, observation, 2-14-17. Weight report is and interview, the facility falled to notify the reviewed weekly by NHA or physican of a significant weight loss for 1 resident (#114) of 3 residents reviewed for nutrition, of 45 designee. The DON or designee sampled residents reviewed, resulting in an 18.8 will notify the physician of pound (10.6%) weight loss in 21 days (harm) for significant weight loss and will Resident#114. receive and implement any The findings included: physician orders. RNs and LPNs have been educated regarding Medical record review revealed Resident #114 was admitted to the facility on 1/4/17 with physician notification of diagnoses including Pneumonia, Clostridium significant weight loss. difficile, Colitis, Hypertension, Cognitive Documentation of training is Impairment, Hyperlipidemia, and Percutaneous Endoscopic Gastrostomy (PEG tube- tube being maintained at the surgically placed in the stomach to provide community. nutrition when oral intake is not adequate).

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revealed the following: 1/4/17: 176.8 pounds (lbs)

1/5/17: 176.8 lbs 1/7/17 175.4 lbs

Medical record review of the resident's weights

1/23/17: 169 lbs (17.8 lb [10%] loss in 19 days) 1/25/17: 158 lbs (18.8 lb [10.6%] loss in 21 days)

Medical record review of the Physicians

Event IO; 071811

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If continuation sheet Page 2 of 16

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES			FOR	OZIOTZINIT MAPPIROVED
1 STATEMEN	t of deficiencies of correction	(X1) PROVIDERSUPPLIERICE (X.) (DENTIFICATION NUMBER		PLE-CENSTRUCTION		093840391 TERURVEY TERURVEY
()	,	445481	e wite			
NAME OF	PROVIDER OR SUPPLIER			STREEPADDRESS (GITY STATE VID	Ö	/25/2017
ASBUR	/ PLACE AT KINGSPO	ŔŢ		100 NESHEBLAND LANE KINGSPORT, TN 37480	LOUE The second se	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREEIX PACE	PROVIDER SHEAT OF CO EACH CORRECTIVE/ACTIO CROSS REFERENCED TO THE DEFICIENCY	HRECTION: NSHOULD BE APPROPRIATE	COLPTETION
F 157	Recapulation orders revealed "weigh re three days starting to	dated January 2017; esident: every one day for 1/6/17,"	Fijā	will be monitored to en the deficient practice w recur; i.e. what quality	sure vili not	
	revealed "his (resided pounds which is	ngistered Dietloian (RD) on I, at the Nuises Station dent's weight on 1/23/17 was a a severe weight loss"		assurance program will into place: NHA or designee will au	dit the	2)16/17
	have heard about the told me back some to loss but not this acute confirmed "if an isse	with the resident's physician M revealed." This is the first I is weight loss the facility had the ago he had some weight le loss" Further interview sue with the weights comes no "	! .	medical record of reside with significant weight lensure attending physic been notified. Audits weekly x 8, because x 4. Results will be reposed.	oss to ian has ill be iiweekly	5
SS=D	URUGS IF DEEMED (c)(7) The right to sel	f-administermedications if	F 176	Quality Assurance/Perfo	rmance :	
	by:	determined that this percentage I is not met as evidenced		F 176 What corrective action(c) will	
1 -:	and interview, the fac resident (#148) was s	ISSESSED for: 8 Medication, of 4 residents		be accomplished for the residents found to have affected by the deficien	se been	
	The findings (notuded Medical record review was admitted to the to liagnoses including t	revealed Resident #148		Resident #148 was disch to home on 02/04/17.	arged	
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Facility ID: TN8210

continuation sheet Page 3 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB:NO. 0238-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING ... 445481 B. WING. NAME OF PROVIDER OR SUPPLIER 01/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION PREFIX REQULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY F 176 | Continued From page 3 How you will identify other F 176 Dystipidemia, residents having the potential to be affected by the same Medical record review of a Physician's Recapitulation orders dated 1/17/17 revealed, deficient practice and what "...Albuterol ftype of breathing corrective action will be taken: treatment]...Nebulization...every four hours starting 1/17/17..." Further review revealed no All residents receiving order or assessment for the resident to self-administer medications. medications via nebulizer have been identified and assessed Observation of Licensed Practical Nurse (LPN) #1 during medication administration on 1/24/17 at for the ability to self-administer 2-16-17 8:10 AM, in Resident #148's room, revealed the medication. Residents deemed LPN placed a breathing treatment mask around competent to self-administer the resident's mouth and left the room, while the treatment continued to be administered. medications via nebulizer have received education on the Interview with LPN #1 on 1/24/17 at 9:34 AM, at the nurse's station, confirmed the resident had components of the task. not been assessed for self-administration of Residents will be reassessed medications prior to self-administration. quarterly or with a significant F 273 463.20(b)(2)(i) COMPREHENSIVE 7 273 ASSESSMENT 14 DAYS AFTER ADMIT \$8=G change in condition. FIRE (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 871311

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Facility ID: TN8210

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORMAPPROVED STATEMENT OF DEFICIENCIES 1ee0<u>-88e0 on amo</u> (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTITUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 4454B1 R. WING NAME OF PROVIDER OR SUPPLIER 01/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F176 F 273 Continued From page 4 P-273 What measures will be put in or therapeutic leave.) This REQUIREMENT is not met as evidenced to place or what systemic bγ: changes will you make to Based on medical record review and interview. ensure that the deficient the facility failed to complete timely Minimum Data Set (MDS) assessments for 2 residents practice does not recur: (#114 and #145) of 45 sampled residents. The facility's failure to complete the MDS Policy for self-administration of assessments resulted in a failure to identify a nebulized medications significant weight loss of 18.8 pounds (10.6%) in 21 days (harm) for Resident#114. reviewed and updated 2-16-17. 7 ا حا کی RNs and LPNs have been The findings included: educated regarding the policy Medical record review revealed Resident #114 and procedure for the self-

was admitted to the facility on 1/4/17 with diagnoses including Pneumonia, Clostridium difficile, Colliis, Hypertension, Cognitive Impalment, Hyperlipidemia, and Percutaneous Endoscopic Gastrostomy (PEG tube-tube surgically placed in the stomach to provide nutrition when oral intake is not adequate).

Medical record review revealed there was not a 5 day MDS assessment (due 1/9/17) or a 14 day MDS assessment (due 1/16/17) available in the medical record.

Medical record review of the resident's weights revealed the following: 1/4/17: 176.8 pounds (ibs)

1/5/17: 176.8 lbs 1/7/17 175.4 lbs

1/23/17: 159 lbs (17.8 lb [10%] loss in 19 days) 1/25/17: 158 lbs (18.8 lb [10.6%] loss in 21 days)

Interview with the MDS coordinator on 1/24/17 at 2:17 PM, in the MDS office, confirmed Resident

#114's MDS 5 day and 14 day assessments were l'ORM CHES-2567(02-99) Provious Versions Obsolete

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If continuation sheet Page 5 of 16

administration of medication.

Documentation of the training

is being maintained at the

How the corrective action(s)

will be monitored to ensure

recur; i.e. what quality

the deficient practice will not

assurance program will be put

community. .

into place:

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERIBUPPLIERICIJA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILUING COMPLETED 445481 NAME OF PROVIDER OR SUPPLIER 01/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37660 SUMMARY SYATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID. PREFIX FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 273 Continued From page 5 DON or designee will audit on F 273 not completed. Continued interview confirmed weekly basis residents receiving "...No, I haven't done it yet..." nebulized medications to Interview with the Director of Nursing (DON) on ensure assessment and 1/25/17 at 3:22 PM, in the private dining, education has been completed. confirmed if the facilty had completed the MDS as scheduled, the severe weight loss loss would Audits will be weekly x 4 and have been identified prior to 1/25/17. monthly x 2. Results will be reported to Quality Medical record review revealed Resident #146 was admitted to the facility on 1/7/17 with Assurance/Performance diagnoses including Acute on Chronic Diastollo Improvement Committee Congestive Heart Failure, Stage 4 Renal Failure, Acute Urinary Retention, Acute on Chronic monthly. Respiratory Failure with Hypoxia, Bilateral Pneumonia, Paroxysmal Atrial-Fibrillation, Hypertension, Dementia, and Sacral Wound. F273 F243 Medical record review revealed there was not a 5 day MDS assessment (due 1/12/17) or a 14 day What corrective action(s) will MDS assessment (due 1/21/17) available in the be accomplished for those medical record. residents found to have been Interview with the MDS coordinator on 1/24/17 at affected by the deficient 3:24 PM, in the MDS office, confirmed the 5 day practice: and the 14 day MDS assessment for Resident #145 was not completed. Further interview MDS assessments completed by confirmed "...I'm behind..." the MDS Coordinator for residents #114 and #145 on See F325 F 325 1-24-17. 483.25(g)(1)(3) MAINTAIN NUTRITION STATUS -F-826 **UNLESS UNAVOIDABLE** 88≃G i (g) Assisted nutrition and hydrasion_ (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and

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Facility ID: TN6210

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AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) C	O. 0938-039 ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER	445481	B. WING_		lo	1/25/2017
	·		ı	STREET ADDRESS, CITY, STATE, ZIP GODE		-14014
ASBURY	PLACE AT KINGSPO	RT		100 NETHERLAND LANE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		KINGSPORT, TN 37660	·	
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F 325	Continued From pag	ge 8	~ [-9 2	5 How you will identify other		
	enteral fluids). Base	d on a realdenta	ļ. '			1
	comprehensive asse	essment, the facility must	FRAR	-		
ł	ensure that a reside	nt		to be affected by the same		
	(1) Maintains accept	able parameters of nutritional		deficient practice and wha		
]	arburs, such as usus	ll 000V weight or desirable		corrective action will be ta	aken;	
	sooy weight range a	NG Glectrolyte haleace, unlaws		MDS account		Ì
	this is not possible a	condition demonstrates that resident preferences		MDS assessment report		1
ļ	indicate otherwise;	Lestneut bieletelices		reviewed for all residents of		1 . :
- !	•	_		1-25-17 by MD\$ coordinate		1
	(3) is offered a thera	peutic diet when there is a		with ongoing daily review.		•
	nutritional problem and the health care provider orders a therapeutic diet.			reviewed the MDS assessin	nent	
	This REQUIREMEN	is not met as evidenced		report on 2-14-17 and		
	Dy:			confirmed all MDS complet	ted.	
	Based On review of the	facility policy, medical record and interview, the facility		All MDS assessments are		1.
ļ i	railed to identify and i	implement interventions for a s for 1 resident (#114) of 3		current as of 2-17-17.		2-11-11
11	residents reviewed fo	r Duffilion of 46 sampled (What measures will be put	t in	
];	and implement interv	he facility's fallure to identify entions resulted in an 18.6		to place or what systemic]
- 11	npisw (%8.07) anuoq	t loss in 21 days (harm) for		changes will you make to		
- 11	Resident #114.			ensure that the deficient		
ļ¬	The findings included	,]		practice does not recur:		1.
-	Review of facility and	y Weight Management last		The NHA or designee will		
, j r	evised on 7/7/17 revi	39led "the intendisciplingor		review the MDS Schedule		
	resw fin i i will cookgi	nate carefully to ensure		weekly to assure that all Mi	DC)	}
1 12	noper weight managi sach resident will bo	ement for all residents[1]		<u>-</u>	U3	
ŧ	he following 2 davs. t	veighed upon admission, hen weekly or monthly as		are completed in a timely		
į a	illected by the IDT in	coordination with the		manner.		
	inysician[2] the wek	I di betgemusch ed illw sidt				
Į	ne medical record an	d periodically reviewed by				
a	ne IDT[3] each residdress significant we	dent's care plan will light changes[4] any	ļ	·	i	ľ
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		Soleta Event ID: 871311	Fac	Ality ID; TN8210 (f.contian	miles about	Page 7 of 16

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SULPEMEN	TOF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) FROVIDER/SUPPLIER/CLIA	OV23 MI II 5	TIPLE CONSTRUCTION	, , , ,	MAPPRO D. 0938 -0
رين الايت	OF CORRECTION	IDENTIFICATION NUMBER		ng	(X3) D/	NTE SURVE MPLETED
NAME OF	PROVIDER OR SUPPLIER	445481	B. WING			1/28/2017
	PLACE AT KINGSP	ÖRT		STREET ADDRESS, CITY, STATE, ZIP 100 NETHERLAND LANE KINGSPORT, TN 37660	CODE	125/201
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	Medical record reviews admitted to the diagnoses including difficile, Colitis, Hypert Endoscopic Gastro surgically placed in nutrition when oral Medical record reviews and advancing slow pounds" Medical record reviews 1/5/17: 176.8 lbs 1/5/17: 176.8 lbs 1/5/17: 158 lbs (1/5/17: 1/5/	the Registered Dietician iew revealed Resident #114 e facility on 1/4/17 with g Pneumonia, Clostridium pertension, Cognitive lipidemia, and Percutaneous stomy (PEG tube- tube the stomach to provide intake is not adequate). ew of the resident's weights ing: ds (lbs) 7.8 lb [10%] loss in 19 days) 8.8 lb [10.6%] loss in 21 days) ew of a Nurse's Note dated evealed "has a PEG tube, uhe feedings continuously, ly to 75 cc/hrweight 176.8 ew of the resident's Care Plan ed "keep head of bed interal feedings as usult as needed" w of the Physicians dated January 2017, e feedingat 30 cc [cubic thour]continuous starting ent; every one day for three	FOR	Policy and procedure	for MDS Ite and corporate surance intation of naintained Ition(s) ensure will not y It be put Vill be weeks by tesuits slity e	

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Facility ID: TN8210

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F 325	Medical record revie	W of a Physician's omnress	F 325	F325	र ज्	
	note dated 1/6/17 re hospitalized with sep respiratory failure withospital he was not a nutrition or fluids so nutritional support' Medical record review Assessment dated 1 "diet order: Puree intake: 0% today r/t. [Further review reves [inches]weight: 177 Weight]: 178 lbsch yes, PEG tube" Further review revealed "pt feeding order: [tube to [millifiters per hour] we review revealed "pt feeding] goal tolerating 82% of estimated ner healing. Pt also on Falert enough to eat to [gastrointestinal] fund pureed diet, need for revealed "recomme at 75 ml/hr with 30 ml see if intake of purees supplement TF intake Medical record review 1/10/17 at 6:40 AM renon-tender T/F ongo feeding pladement chinol residual noted" Medical record review	wealed "recently is is, dehydration, and the hypoxiewhile in the eating or taking adequate a PEG tube was inserted for w of a Nutritional (6/17, with no lime, revealedsupplements: none; meal related to) being out of it" lied "height 72" pounds!BW [Ideal Body ewing/swallowing difficulty riher review revealed "tube feeding) @ 75 ml/hr //ith 30 ml/hr flush" Further to [Ipatient] at TF [tube ing well. Current TF providing eds to promote wound fureed diet, but hasn't been iday. Altered Gillion r/t advanced age also TF" Further review and continue [tube feeding] water flush. Will follow to diet is sufficient to		What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice: Resident # 114 identified with weight loss. Weight continuate fluctuate: 1/30/17 - 158.4 pounds; 2/6/17 - 164.8 pounds; 2/6/17 - 164.8 pounds. Physician contacted on 1/26/17 with nonew orders at that time. Physician visited with resider on 2/15/17. New nutritional interventions ordered at that time and implemented.	th les 4 nds; 17 –	

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Facility ID: TN8210

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			_		NGSPORT, TN 37660		
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F 326	Cartinuos Francis		[-		How you will identify other		
I DZ.G	A A A S A A A A A A A A A A A A A A A A	je v fic] for C-Diff (Clostridium	į E.	325	residents having the potentia	İ	
	amicile infection cau	Sino diambestrecently			to be affected by the same		
	nospitaliz ed With set	ISIS, dehvätalinn reeniralna	1		deficient practice and what		
	mental status chang	PNA [pneumonia], and es" Further review revealed			corrective action will be taken	1:	
	physical exam; de	neral, well developed, well frailabdomen; normal			The weight log was reviewed		
	power sounds, non-b	efficer, no abdominal mass			on 2-16-17 to identify resident		
	Paipated, soft PEG t	ube in olace "Eurthor	Ì		triggering for physician		· -
	review revealed "di feedings"	jet; bries sug trips			notification and nutritional		
	_	•	İ		interventions implemented as		
	ream (IDT) report da	w of the Interdisoplinary sted 1/11/17 revealed the	:		indicated,		
	discussed.	igs and weights was not			What measures will be put in		
	Medical record review	v of a Nurses Note dated			to place or what systemic		
j	1/13/17 at 10:10 AM	revealed" feeding via nea			changes will you make to		
	lube pump at 75 cc/h	r, check for residual"			ensure that the deficient		1 1
1	Medical record review	v of a Nurses Note dated			practice does not recur:		
	1/15/17 at 11:44 PM [Gedinal placement of	revealed "T/F (tube hecked by auscultation with			Policy and procedure for		
10	residual noted, T/F	running as ordered"	·		significant weight loss reviewed	l	
ا ا	Viedical record review	of a Speech Therapy (ST)			2/14/17 Weight report is	•	
· I	iote dated 1/16/17 at	6:32 PM revealed " notion!			reviewed weekly by the		
	seem with continuous	feeds turned off to promote			Registered Dietitian to ensure		
	ig negrated with no overts	ree and NTL [nectar thick s/s (signs and symptoms] of			that the nutritional Plan of Care	!	
É	espiration, fatigue, or	respiratory decline"			meets resident's needs. RNs]
1		of the IDT report dated			and LPNs have been educated	i	
1	/70/17 revealed the r	esideni was not discussed			regarding policy and procedure		ļ
10	i the meeting related	to the tube feedings or			for significant weight loss,		İ
) V	reights.)			Training documentation is]	ľ
N	ledical record review	of a Speech Therepy note			being maintained at the		
	(02-96) Previous Versions Obs		-	Excl4ty	community.		
			•	~~144	•	n chast D	araa do anel

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 02/07/2017
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	_		FOR	MAPPROVED
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(K2) MULT A. BUILDIN	IPLE CONSTRUCTION		O. 0938-0391 ATE SURVEY OMPLETED
<u> </u>		445481	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, 0,</u>	1 <i>1251</i> 2017
ASBURY	PLACE AT KINGSPO	DT		100 NETHERLAND LANE	•	
			ŀ	KINGSPORT, TN 37660		
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CAN	
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	(EAGH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEPICIENCY)	h sc	GONE-LETION DATE
F 325	Continued From pag	ie 10	F 32	How the corrective action(s		
	dated 1/20/17 at 1:3	5 PM revealed a nation)	r 32:	will be monitored to ensure)	
	agreed to sit upright	for meal_nation; then set up				
	and roterated puree.	diet with no overt s/s of oximately 50% of meal.		the deficient practice will no)t	
i	Panents daughter c	8lled from out of		recur; i.e. what quality		
- 1	towndiscussed pla	n for…bolus feeris va 📗 📗		assurance program will be p	ut]
ŀ	continuous feeding.,	, R		into place:		
	Medical record review	w of a Nurses Note dated		Weekly weight report will be		211017
	1/23/17 at 11:29 PM	revealed "tatient dose		reviewed by DON or designed		ا الماريد
ļ	nave ir cunning as c	Ordered. O residual noted by		to identify simple-	3	
}	achigners to to desiles	it checked by auscultation"		to identify significant weight		
- 1	Observation on 1/25/	/17 at 12:30 PM, in the		losses. Audit will be conducte	ed	1 1
j	residents room, reve	aled the resident was wind		by the DON or designee to		
\cap \perp	on we ned sud file if	the feeding was turned off.		determine that interventions		
~ I	Interview with the Re	gistered Dietition (RD) on		are in place to meet the		
	1/20/17 at 12:44 PM.	at the Nurses Station		resident's needs. Significant	-	
	revealed "the residi feedings at 75 colling	ent is on continuous tube we have advanced him to a		weight changes will be		1
11	hnies olst SUO 21, PSi	id he was only eating 25% of L		discussed in the		1
Į !	ins ineat,".Nis Weldut (00 1/23/17 Was 150 nounde 📗		Interdisciplinary Nutrition at		1
1	which is a severe we! ask for a re-weigh if (ght lossI would normally saw this drastic weight loss		Risk Meeting weekly. Results]
1	onrus is office all 100 Pi	iliding now at a doctor's		will be reported to Quality		
	appoin(ment"			Assurance/Performance		}
· 1	Nterview with License	ed Practical Nurse (LPN) #3		Improvement Committee		
	on 1/25/17 at 2:30 PM	I. at the Magnolia Nurse's		monthly.		
1 8	station, revealed "w	e have weekly int				
	neolings and discuss	residents with weight useed this resident for				ĺ
1 2	veight loss"	masen dus lesident jol			,	j
Ì	-			•		
1	nierview with the RD. he conference room	on 1/25/17 at 2:35 PM, in revealed "during my first	ĺ			
E	waluation i wanted to	make sure the resident			ļ	
v	vas stable and I was I	not 100% sure what the			-	
RM CMS-2567	(02-99) Previous Versions Ob	solele Event ID: 87131(Fee	illy ID: TN8210 If continues		200 11 of 18
				- II CAUTANIAW	w onent L	2286 49 AF78

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445481 B. WING NAME OF PROVIDER OR SUPPLIER Q1/25/2017 STREET ADDRESS, GITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 87660 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (L'ACH GORRECTIVE ACTION STIQUED BE m (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (XS) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 325 Continued From page 11 F 325 resident needed as far as supplemental feedings [versus] continuous feedings...] wanted to establish a baseline for the resident... "Further interview revealed "...my understanding was the tube feedings were being stopped prior to meals to see if the patient could eat and until the ST saw the patient... I was made aware of this [the tube feedings being stopped for meals] last week..." Further interview revealed "... I asked for a re-weigh on 1/16/17 but I was never told if the weight was done or what the weight was...! did not write for the tube feedings to be held, it may have been the ST...I am not sure how long this had been going on..." Further interview revealed "...his weight on 1/23/17 was 159 pounds and revealed a severe weight loss...I did not see the weight until today..." Continued interview revealed "...the IDT meets weekly but I do not remember discussing the patient related to weight loss or tube feedings...the weight on 1/16/17 would have certainly established a baseline for any weight loss..." Telephone interview with the resident's physician on 1/25/17 at 3:10 PM revealed "...this is the first I have heard about this weight loss,...the facility had told me back some time ago he had some weight loss but not this acute loss ... "Further interview revealed "...he has dementia and had some infections which were being treated with antibiotics...he has a PEG tube with tube feedings ordered...the RD and ST have been following him..." Continued interview revealed "...I do have

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if he could eat..."

input related to the tube feedings...we were trying to get him to 75 cc/hr and add a puree diet to see

Interview with the Director of Nursing on 1/25/17 at 3:22 PM, in the private dining room, revealed

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO, 0936-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING ___ COMPLISTED 445481 **B. WING** NAME OF PROVIDER OR SUPPLIER 01/25/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT KINGSPORT 100 NETHERLAND LANE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PŘÉFIX PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE EACH DEFICIENCY MUST BE PRECEDED BY FULL ΙĐ (XS) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) Continued From page 12 1 "...l was not made aware of the tube feeding being stopped prior to meals until today...If I had known this I would have certainly evaluated the situation more closely to see what needed to be done..." Further interview revealed "...if the tube feedings were being held at any time there should be documentation by the ST, the RD, and the nurses related to when the feedings were stopped, why they were stopped, when they were started back, but there is no documentation..." Further interview revealed "...apparently the ST had asked the feedings to be stopped prior to meals to see how much residual was in the tube feedings...the nurses note indicated no residual..." Further interview revealed "....I do not F441 remember the weights for the resident being discussed in the IDT...the RD is instrumental in What corrective action(s) will addressing weight loss..." Continued interview be accomplished for those revealed "...I was not aware the RD had asked for a re-weigh on 1/16/17..." Further interview , residents found to have been confirmed the tube feedings were withheld affected by the deficient without a physician's order, the weight of 159 pounds (17.8 pound loss) on 1/23/17 was not practice: addressed by the facility until 1/25/17, and confirmed the facility failed to identify and Resident #80 remains free of implement interventions for a resident with a signs and symptoms of significant weight loss, 483.89(a)(1)(2)(4)(e)(f) INFECTION CONTROL. infection and was not adversely F 441 F 441 SS=D PREVENT SPREAD, LINENS affected by the handwashing practice. LPN #2 has been (a) Infection prevention and control program. reeducated on the hand The facility must establish an infection prevention washing and glove use during and control program (IPCP) that must include, at medication administration. a minimum, the following elements: Documentation of the training A system for preventing, identifying, reporting. is being maintained at the investigating, and controlling infections and community.

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			વ	RINTE): 02/07/2017
CTATEMENT	NS FOR MEDICARE	& MEDICAID SERVICES				MB NO	MAPPROVED 2. 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE GONSTRUCTION	(X3) DA	TE SURVEY MPLETED
U NAME OF	FROVIDER OR SUPPLIER	445481	B. WING			0.4	/25/2017
NAME OF	PROVIDER OR SUPPLIER	•		8	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	TEGIED (1
ASBURY	PLACE AT KINGSPO				00 NETHERLAND LANE UNGSPORT, TN 37660		
(X4) ID PREFIX TAG	i (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AGTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE -	COMPLETION DATE
	volunteers, visitors, providing services userrangement based conducted according accepted national strimplementation is Place (2) Written standard for the program, whitimited to: (i) A system of survey possible communication to before they can sprefacility; (ii) When and to who communicable disease reported; (iii) Standard and traits be followed to previous president; including but the type and durated pending upon the incommunication and the depending upon the incommunication and the services and durated pending upon the incommunication and the services and durated pending upon the incommunication are services and durated pending upon the incommunication are services and durated pending upon the incommunication acceptance of the services are serviced as a service and the services are services as a services are servi	ases for all residents, staff, and other individuals and other individuals nder a contractual upon the facility assessment as to §483.70(e) and following andards (facility assessment hase 2); s, policies, and procedures on must include, but are not alliance designed to identify the diseases or infections and to other persons in the ase or infections should be assessed precautions went spread of infections; solation should be used for a at not limited to:	F 44	41	How you will identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be taken Resident number 80 resides of Magnolia hall. LPN #2 works of Magnolia hall. LPN #2 works of Magnolia hall. 2-17-17 FDB Report in Vision pulled for antinfective medications ordered for Magnolia hall from the data the error was made plus three days. No antibiotics were ordered for residents residing on the hall that the error was made. Residents on Magnolia were not adversely affected by the handwashing practice.	l n on -	
	involved, and (B) A requirement tha least restrictive possi circumstances. (v) The circumstance must prohibit employ	at the isolation should be the ble for the resident under the s under which the facility cos with a communicable			· ·		5 5 5
,	contact with residents	kin lesions from direct s or their food, If direct					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	(K1) PROVIDER/SUPPLIER/CUA	Tage 100		- C	<u>MR MO</u>	<u>. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(XS) DAT	TE SURVEY MPI, ETED
<u> </u>		445481	# WING			01	/25/201 7
	PROVIDER OR SUPPLIER FPLACE AT KINGSPO	RY		10	TREET ADDRESS, CITY, STATE, ZIP CODE TO NETHERLAND LANE INGSPORT, TN 37660	. 01	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	1X	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	(X5) COMPLETION DATE
	contact will transmit (vi) The hand hygier by staff involved in c (4) A system for recunder the facility's if actions taken by the (e) Linens. Personn process, and transp spread of infection. (f) Annual review. T annual review of its program; as necess This REQUIREMEN by: Based on review of and interview, the fa infection control guid during medication at during medication at during includer (#80) of 6 residents sampled. The findings includer Review of facility pol 1/1/17 revealed "al handwashing proced infection and disease residents, and visitor "wash hands before contactbefore and equipment used in 8 Precautionswhene	the disease; and ne procedures to be followed lirect resident contact. Ording incidents identified of the corrective of acility. It is must handle, store, out linens so as to prevent the ordinary will conduct an IPCP and update their ary. This not met as evidenced of acility policy, observation, cility failed to follow standard delines for hand hygiene diministration for 1 Resident observed of 45 residents d: icy Handwashing dated of the personnel will follow the lare to prevent the spread of the to other personnel, s" Further review revealed e and after each resident after using protective tandard ver doubt of contamination" led "using gloves does not ghand hygiene"	F	141	What measures will be put in to place or what systemic changes will you make to ensure that the deficient practice does not recur: Hand washing/glove use during medication administration policies reviewed and updated DON or designee educated RNs and LPNs regarding hand washing and glove use during medication administration. Documentation of the training is being maintained at the community.		

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA JOENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	OXID NO. 09	
9]		(X3) DATE S COMPL	ÉTED
	Continued From page	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION; Je 15 TEEC Practical Nurse (LPN)	1	TREET ADDRESS, CITY, STATE, ZIP CODE DO NETHERLAND LANE INGSPORT, TN 37660 PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLENCY) How the corrective action(s)	nas Ja	(XA) OMPLE DATE
	administration on the the nurse donned glandications to a reserve aled the nurse of the floor, in the reserve aled the nurse of the floor, in the reserve aled the nurse salingections to the resire or santizing the hand interview with LPN # the Magnolia Hallway to change the gloves picking up a medical administering an injection with the Direction of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering an injection of the picking up a medical administering up a medical admin	2 on 1/25/17 at 8:30 AM, on y, confirmed the nurse failed and sanitize the hands after ion from the floor and prior to clion to the patient. The private dining room, failed to follow the facility.		will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be puinto place: DON or designee will perform random hand washing observations of RNs and LPNs during medication administration with a minimum of 5 per week x 4 weeks, then per week x 4 weeks. Results will be reported to Quality Assurance/Performance Improvement Committee monthly.	t 2	m
	(02-98) Prévious Vorsions ()					

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